STATE OF MICHIGAN

DEPARTMENT OF LABOR & ECONOMIC GROWTH

OFFICE OF FINANCIAL AND INSURANCE REGULATION

Before the Commissioner of Financial and Insurance Regulation

In the matter of

XXXXX
Petitioner **File No. 88720-001-SF**

v

Blue Cross and Blue Shield of Michigan
Respondent
_____/

Issued and entered
This 12th day of May 2008
by Ken Ross
Commissioner

ORDER

I
PROCEDURAL BACKGROUND

On March 26, 2008, XXXXX (Petitioner) filed a request for external review with the Commissioner of Financial and Insurance Regulation under Public Act No. 495 of 2006 (Act 495), MCL 550.1951 *et seq*. The Commissioner reviewed the request and accepted it on April 2, 2008.

Under Section 2(2) of Act 495, MCL 550.1952(2), the Commissioner conducts this external review as though the Petitioner was a covered person under the Patient's Right to Independent Review Act, MCL 550.1901 *et seq*.

The Commissioner notified Blue Cross and Blue Shield of Michigan (BCBSM) of the external review and requested the information used in making its adverse determination. The Commissioner received BCBSM's response on April 9, 2008.

The Petitioner is enrolled for health coverage through the Michigan Public School Employees Retirement System (MPSERS), a self-funded group. BCBSM administers the plan. The issue in this external review can be decided by a contractual analysis. The contract involved

here is the MPSERS/BCBSM *Your Benefit Guide* (the guide), the document that describes the Petitioner's coverage. The Commissioner reviews contractual issues pursuant to MCL 550.1911(7). This matter does not require a medical opinion from an independent review organization.

II
FACTUAL BACKGROUND

On November 21, 2007, the Petitioner received surgical services at Sparrow Health System from XXXXX, a non-participating provider with XXXXX The doctor charged $16,666.04 and BCBSM paid $4,422.97 for this care.

The Petitioner appealed BCBSM's payment amount. BCBSM held a managerial-level conference on March 3, 2008, and issued a final adverse determination dated March 5, 2008.

III
ISSUE

Is BCBSM required to pay an additional amount for the Petitioner's November 21, 2007 surgery?

IV
ANALYSIS

Petitioner's Argument

The Petitioner relates that a herniated disk was pressing on his spinal cord and caused pain and dizzy spells. After two trips to two hospitals, XXXXX, recommended surgery.

Since the Petitioner was returning to the Lansing area, XXXXX was recommended to perform the surgery. By the Petitioner's calculation, BCBSM paid only 26% of the amount charged by XXXXX for his surgery. The Petitioner argues that BCBSM should pay ay least 70% of the amount charged.

BCBSM's Argument

BCBSM says that the guide clearly states that BCBSM pays its "approved amount" for covered services. The approved amount is the lesser of the provider's charge or BCBSM's maximum payment level for the service. The guide does not guarantee that charges will be paid in

full and also indicates that there are payment limits for multiple surgeries during the same operating session. Moreover, since XXXXX does not participate with BCBSM, he is not required to accept BCBSM's approved amount as payment in full and may bill the Petitioner for the difference between his charge and BCBSM's payment.

The amounts charged by the surgeon and the amounts paid by BCBSM for the November 21, 2007, surgery are listed below.

Procedure Code	Amount Charged by Surgeon	BCBSM's Maximum Payment Level	BCBSM's Approved Amount	Amount Paid by BCBSM	Balance Owed by Petitioner
63075	$5,674.50	$2,077.63	$2,077.63	$2,077.63	$3,596.87
22554	$5,132.50	$1962.11	$981.05*	$981.05*	$4,151.45
22845	$4,530.04	$1,184.66	$1,184.66	$1,184.66	$3,345.38
20931	$502.50	$179.63	$179.63	$179.63	$322.87
69990	$826.50	N/A	$0.00**	$0.00**	$826.50
Totals	$16,666.04			$4,422.97	$12,243.07

* BCBSM paid 50% of the approved amount for this service in accordance with the national standard rules recognized by BCBSM on multiple surgeries provided on the same day by the same physician.

** BCBSM did not pay for PC 69990 since the approved amount for the primary procedure includes payment for this service.

The maximum payment level for each service is determined by a resource-based relative value scale (RBRVS), a nationally recognized reimbursement structure developed by and for physicians. The RBRVS reflects the resources required to perform each service is regularly reviewed to address the effects of changing technology, training, and medical practice.

BCBSM contends that it has paid the proper amount for the Petitioner's care and is not required to pay more.

Commissioner's Review

XXXX is a nonparticipating provider. The guide describes how benefits are paid when services are received from a nonparticipating provider. First, BCBSM pays an "approved amount" for covered services -- it does not guarantee that provider charges will be paid in full. "Approved

amount" is defined in the guide: "The maximum payment level approved by Blue Cross Blue Shield of Michigan or the provider's charge for the covered service, whichever is lower." The same approved amount is paid for services from both participating and nonparticipating providers. However, the amount charged by a nonparticipating provider (XXXXX in this case) may be significantly higher than BCBSM's maximum payment level for the service. Since nonparticipating providers have not signed agreements with BCBSM to accept the approved amount as payment in full, the Petitioner must, as the guide explains on page 13, "pay cost difference between provider charge and Blue Cross-approved amount."

Second, BCBSM also pays for surgery based on the national standard that pays 100% of the approved amount for primary procedures and 50% of the approved amount for a secondary procedure performed during the same operative session. Nothing in the record establishes that the surgery was more complex than as described in the procedure code billed by XXXXX that would warrant an additional payment by BCBSM.

It is not explained in this record why the Petitioner did not use a participating provider. Nevertheless, there is nothing in the language of the guide that requires BCBSM to pay more than its approved amount (or 50% of the approved amount for secondary surgical procedures) to a nonparticipating provider, even if no participating provider was available. The explanation of benefit forms submitted show that BCBSM paid its full approved amount for XXXXX's services. The Petitioner remains responsible for the difference between that payment and XXXXX's charges.

The Commissioner finds that BCBSM is not required to pay any additional amount for the surgery provided the Petitioner on November 21, 2007.

V
ORDER

BCBSM's final adverse determination of March 5, 2008, is upheld. BCBSM is not required to pay an additional amount for the Petitioner's surgery.

This is a final decision of an administrative agency. A person aggrieved by this Order may

seek judicial review no later than 60 days from the date of this Order in the circuit court for the county where the covered person resides or in the circuit court of Ingham County. See MCL 550.1915(1), made applicable by MCL 550.1952(2).

A copy of the petition for judicial review should be sent to the Commissioner of Financial and Insurance Regulation, Health Plans Division, Post Office Box 30220, Lansing, MI 48909-7720.

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Ken Ross
Commissioner